		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0019364

Facility Name: Central Nursing

Address: 2450 North Central Ave (Number) Chicago (City) 60639 (Zip Code)

County: Cook

Telephone Number: (773) 889-1333 **Fax #** (773) 889-1516

IDPA ID Number: 362801271001

Date of Initial License for Current Owners: 01/01/1973

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[X]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Sanford Alper **Telephone Number:** (847) 647-6600

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 11/01/1999 to 10/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	(Date)
	(Print Name and Title)	Sanford Alper - Principal
	(Firm Name & Address)	Kessler, Orlean, Silver & Company, P.C. 7400 North Oak Park Avenue, Niles, Illinois 60714
	(Telephone)	(847) 647-6600 Fax #(847)647-7554

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 11/01/1999 Ending: 10/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	245	Skilled (SNF)	245	89,425	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	245	TOTALS	245	89,425	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	75,682	5,408	5,416	86,506	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	75,682	5,408	5,416	86,506	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.74%

D. How many bed-hold days during this year were paid by Public Aid?
1,632 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/1973

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 22 and days of care provided 109

Medicare Intermediary Mutual Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 10/31/2000 Fiscal Year: 10/31/2000

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 11/01/1999 Ending: 10/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	245,665	58,033	13,872	317,570		317,570		317,570			1
2	Food Purchase		169,181		169,181	(20,597)	148,584		148,584			2
3	Housekeeping	164,947	11,779	11,768	188,494		188,494		188,494			3
4	Laundry		4,334	12,918	17,252		17,252		17,252			4
5	Heat and Other Utilities			116,860	116,860		116,860		116,860			5
6	Maintenance	30,225		17,901	48,126		48,126	(1,981)	46,145			6
7	Other (specify):*											7
8	**TOTAL General Services**	440,837	243,327	173,319	857,483	(20,597)	836,886	(1,981)	834,905			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,326,404	84,877	100,989	1,512,270		1,512,270		1,512,270			10
10a	Therapy	37,321		16,800	54,121		54,121		54,121			10a
11	Activities	46,802	759		47,561		47,561		47,561			11
12	Social Services	43,788		3,910	47,698		47,698		47,698			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,454,315	85,636	121,699	1,661,650		1,661,650		1,661,650			16
	C. General Administration											
17	Administrative	165,425			165,425		165,425		165,425			17
18	Directors Fees											18
19	Professional Services			37,708	37,708		37,708	(2,035)	35,673			19
20	Dues, Fees, Subscriptions & Promotions			23,593	23,593		23,593	13	23,606			20
21	Clerical & General Office Expenses	211,823	11,188	8,621	231,632		231,632	2,812	234,444			21
22	Employee Benefits & Payroll Taxes			309,327	309,327	20,597	329,924	15,847	345,771			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,455	1,455		1,455		1,455			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			38,254	38,254		38,254		38,254			26
27	Other (specify):*											27
28	**TOTAL General Administration**	377,248	11,188	418,958	807,394	20,597	827,991	16,637	844,628			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,272,400	340,151	713,976	3,326,527		3,326,527	14,656	3,341,183			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Central Nursing #0019364 Report Period Beginning: 11/01/1999 Ending: 10/31/2000

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			29,448	29,448		29,448	82,663	112,111			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			210,938	210,938		210,938		210,938			33
34	Rent-Facility & Grounds			1,206,269	1,206,269		1,206,269	(1,206,269)				34
35	Rent-Equipment & Vehicles			1,041	1,041		1,041		1,041			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,447,696	1,447,696		1,447,696	(1,123,606)	324,090			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			1,449	1,449		1,449		1,449			39
40	Barber and Beauty Shops			60	60		60		60			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			134,506	134,506		134,506		134,506			42
43	Other (specify):* **Nonallowable costs**			504	504		504	(504)				43
44	**TOTAL Special Cost Centers**			136,519	136,519		136,519	(504)	136,015			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,272,400	340,151	2,298,191	4,910,742		4,910,742	(1,109,454)	3,801,288			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 11/01/1999 Ending: 10/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	25,024	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(179)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(325)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 24,520		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,129,908)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,129,908)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,105,388)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Central Nursing

ID# 0019364

Report Period Beginning: 11/01/1999

Ending: 10/31/2000

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Amortize Deferred Maintenance	$ (1,981)	6	1
2	Franchise Tax	(50)	21	2
3	Collections	(2,035)	19	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(4,066)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Central Nursing # 0019364 **Report Period Beginning:** 11/01/1999 **Ending:** 10/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(1,981)	0	0	0	0	0	0	0	0	0	0	(1,981)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,981)	0	0	0	0	0	0	0	0	0	0	(1,981)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,035)	0	0	0	0	0	0	0	0	0	0	(2,035)	19
20	Fees, Subscriptions & Promotions	0	13	0	0	0	0	0	0	0	0	0	13	20
21	Clerical & General Office Expenses	(50)	2,862	0	0	0	0	0	0	0	0	0	2,812	21
22	Employee Benefits & Payroll Taxes	0	15,847	0	0	0	0	0	0	0	0	0	15,847	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(2,085)	18,722	0	0	0	0	0	0	0	0	0	16,637	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(4,066)	18,722	0	0	0	0	0	0	0	0	0	14,656	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Central Nursing # 0019364 **Report Period Beginning:** 11/01/1999 **Ending:** 10/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	25,024	57,639	0	0	0	0	0	0	0	0	0	82,663	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(1,206,269)	0	0	0	0	0	0	0	0	0	(1,206,269)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	25,024	(1,148,630)	0	0	0	0	0	0	0	0	0	(1,123,606)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(504)	0	0	0	0	0	0	0	0	0	0	(504)	43
44	**TOTAL Special Cost Centers**	(504)	0	0	0	0	0	0	0	0	0	0	(504)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	20,454	(1,129,908)	0	0	0	0	0	0	0	0	0	(1,109,454)	45

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 11/01/1999 Ending: 10/31/2000

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Marvin Mermelstein	50.00%	Winston Manor Nursing Home	Chicago	Nivram	Chicago	Nursing Home
Joseph Mermelstein	50.00%	Emerald Park Nursing Center	Evergreen Park	Management, Inc.		Management
		Balmoral Home	Chicago			
		Sovereign Healthcare, LLC	Chicago			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	Bank Charges	$	Nivram Management, Inc.	50.00%	$ 13	$ 13	1
2	V	21	Office Expense		Nivram Management, Inc.	50.00%	94	94	2
3	V	21	Supplies		Nivram Management, Inc.	50.00%	2,021	2,021	3
4	V	20	Franchise Tax		Nivram Management, Inc.	50.00%	13	13	4
5	V	22	Payroll Taxes		Nivram Management, Inc.	50.00%	15,847	15,847	5
6	V	21	Telephone		Nivram Management, Inc.	50.00%	734	734	6
7	V	34	Rent	1,206,269	Henry Mermelstein	0.00%		(1,206,269)	7
8	V	30	Depreciation		Henry Mermelstein	0.00%	57,639	57,639	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,206,269			$ 76,361	$ * (1,129,908)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 11/01/1999 Ending: 10/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Henry Mermelstein	Administrator	Administrative	None	200,000	48	60.00%	Salary	$ 120,000	L17, Col 1	1
2	Louise Mermelstein	Dietary Supervisor	Support	None	75,000	31	39.00%	Salary	29,250	L1, Col 1	2
3	Marvin Mermelstein	Plant Supervisor	Support	50.00%	48,300	4	25.00%	Salary	12,075	L6, Col 1	3
4	Doreen Mermelstein	Administrative Asst.	Clerical	None	89,560	16	26.00%	Salary	23,293	L21, Col 1	4
5											5
6	Marvin Mermelstein	Asst Administrator	Administrative	See Above	181,700	16	25.00%	Salary	45,425	L17, Col 1	6
7	Joseph Mermelstein	Owner	Administrative	50.00%	80,000	5	N/A	Salary	30,722	L21, Col 1	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 260,765		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 11/01/1999 Ending: 0/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Nivram Management, Inc.
Street Address: 2155 West Pierce
City / State / Zip Code: Chicago, IL 60622
Phone Number: (773) 252-3208
Fax Number: (773) 252-3688

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Bank Charges	Resident Beds	942	5	$ 50	$	245	$ 13	1
2	21	Office Expenses	Resident Beds	942	5	361		245	94	2
3	21	Supplies	Resident Beds	942	5	7,772		245	2,021	3
4	20	Franchise Tax	Resident Beds	942	5	50		245	13	4
5	22	Payroll Tax	Resident Beds	942	5	60,925		245	15,847	5
6	21	Telephone	Resident Beds	942	5	2,823		245	734	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 71,981	$		$ 18,722	25

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 11/01/1999 Ending: 10/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 11/01/1999 Ending: 10/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	193,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	217,338	2
3. Under or (over) accrual (line 2 minus line 1).	$	24,338	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	186,600	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	210,938	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	183,601	8
	1996	189,463	9
	1997	214,990	10
	1998	218,807	11
	1999	217,338	12

1999 Tax Bill = 221,807. Estimated Incease 1.03% = 223,858

10 Months 10/12 = 186,548. Rounded = $186,600

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 11/01/1999 Ending: 10/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 67,185 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	30,000	1973	$ 158,977	1
2					2
3	TOTALS	30,000		$ 158,977	3

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 11/01/1999 Ending: 10/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	245		1973	1973	$ 1,729,156	$	30	$ 57,639	$ 57,639	$ 1,570,229	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Sprinkler System			1976	8,246		20			8,246	9
10	Hot Water Heater			1983	2,156		10			2,156	10
11	Light Fixtures			1984	14,684		10			14,684	11
12	Roof			1984	20,000	1,053	20	1,000	(53)	16,250	12
13	Heating & Air Conditioning			1983	2,924		20	146	146	2,409	13
14	Painting & Decoreting			1983	7,863		8				14
15	Doorways			1986	1,840	97	15	123	26	1,772	15
16	Elevator Upgrade			1986	1,080	57	20	54	(3)	732	16
17	Wall Corner Guard			1987	1,531	49	10		(49)		17
18	Resurface Parking Lot			1987	6,900	219	15	460	241	6,046	18
19	Additions			1988	1,200	38	20	60	22	698	19
20	Heater Foundation			1989	1,000	32	20	50	18	532	20
21	Roof			1990	7,916	251	20	396	145	3,979	21
22	Roof			1990	2,199	70	8		(70)	2,199	22
23	Various Improvements			1990	1,850		8			1,850	23
24	Cubicle Curtains			1992	11,273	358	10	1,127	769	9,277	24
25	HVAC Improvements			1993	8,907		10	892	892	6,689	25
26	Draperies			1993	2,700		10	270	270	2,025	26
27	Tiling			1995	6,600	169	10	660	491	3,630	27
28	Leashold Improvements			1995	15,914		10	1,591	1,591	8,751	28
29	Generator			1996	17,527	449	10	1,753	1,304	7,888	29
30	Roof			1996	4,800	123	10	480	357	2,160	30
31	Door			1997	2,465	63	10	247	184	864	31
32	Wiring for Emergency System			1997	5,000	128	10	500	372	1,750	32
33	Phone System			1997	8,238		10	823	823	2,881	33
34	Architecture			1998	6,000	154	10	600	446	1,500	34
35	Boiler, A/C, Ductwork			1998	16,664	427	10	1,666	1,239	4,165	35
36	TOTAL (lines 4 thru 35)				$ 1,916,633	$ 3,737		$ 70,537	$ 66,800	$ 1,683,362	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 11/01/1999 Ending: 10/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Roofing			1998	54,000	1,385	10	5,400	4,015	13,500	9
10	Parking Lot Improvements			1998	8,000		10	800	800	1,200	10
11	Elevator Improvements			1998	4,450	68	10	445	377	668	11
12	HVAC Improvements			1998	2,820	72	10	282	210	423	12
13	Fire Alarm System & Doors			1999	107,500	2,756	10	10,750	7,994	16,125	13
14	Extended Walls through Ceiling			1999	3,000	77	10	300	223	450	14
15	Elevator Improvements			1999	2,650	68	10	266	198	399	15
16	HVAC Improvements			1999	20,388	523	10	2,038	1,515	3,057	16
17	Landscape Work			1999	4,100	105	10	410	305	615	17
18	Elevator Improvements			2000	89,750	288	10	4,488	4,200	4,488	18
19	HVAC Improvements			2000	23,639	177	10	1,182	1,005	1,182	19
20	Leashold Improvements			2000	7,500	120	10	375	255	375	20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 327,797	$ 5,639		$ 26,736	$ 21,097	$ 42,482	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 11/01/1999 Ending: 10/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 68,858	$ 9,978	$ 7,952	$ (2,026)	8-10 Year	$ 36,370	37
38	Current Year Purchases	17,295	2,471	1,331	(1,140)	10 Years	1,331	38
39	Fully Depreciated Assets	334,931				5-10 Year	332,153	39
40								40
41	TOTALS	$ 421,084	$ 12,449	$ 9,283	$ (3,166)		$ 369,854	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Facility Storage	Storage Trailer	1986	$ 900	$	$	$	4	$ 900	42
43	Administrative	1986 Chrysler	1986	16,095				4	16,095	43
44	Administrative	1987 Chevy	1987	12,510				4	12,510	44
45	See Attached Sch A			41,059	7,623	5,555	(2,068)		27,556	45
46	TOTALS			$ 70,564	$ 7,623	$ 5,555	$ (2,068)		$ 57,061	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 2,895,055	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 29,448	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 112,111	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 82,663	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 2,152,759	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 11/01/1999 Ending: 10/31/2000

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 1,041 Description: Ice Maker $900, Copier $141
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 11/01/1999 Ending: 10/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 11/01/1999 Ending: 10/31/2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care	L39, Col 3	visits		49	1,449		49	1,449	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L 10, Col 3	# of prescrpts				1,721		1,721	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Enternal tube feeding	L 10, Col 3					98,100		98,100	13
14	TOTAL			$	49	$ 1,449	$ 99,821	49	$ 101,270	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 11/01/1999 Ending: 10/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 10/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,454,532	$ 1,454,532	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	210,055	210,055	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	307,818	307,818	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,972,405	$ 1,972,405	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		158,977	13
14	Buildings, at Historical Cost		1,729,156	14
15	Leasehold Improvements, at Historical Cos	431,992	491,122	15
16	Equipment, at Historical Cost	289,071	515,800	16
17	Accumulated Depreciation (book methods)	(282,037)	(2,139,524)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Deposits	500,100	500,100	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 939,126	$ 1,255,631	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,911,531	$ 3,228,036	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 64,321	$ 34,321	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	186,600	186,600	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Sch 17A	1,433,577	1,433,577	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,684,498	$ 1,654,498	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,684,498	$ 1,654,498	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,227,033	$ 1,573,538	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,911,531	$ 3,228,036	48

***(See instructions.)**

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 11/01/1999 Ending: 10/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 554,681	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 554,681	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	3,271,352	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(2,599,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 672,352	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,227,033	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,049,348	1
2	Discounts and Allowances for all Levels	(12,803)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,036,545	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	70,114	5
6	Therapy	2,063	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 72,177	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	3,661	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 3,661	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	54,714	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 54,714	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Vending Machines	14,997	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 14,997	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,182,094	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	857,483	31
32	Health Care	1,661,650	32
33	General Administration	807,394	33
	B. Capital Expense		
34	Ownership	1,447,696	34
	C. Ancillary Expense		
35	Special Cost Centers	2,013	35
36	Provider Participation Fee	134,506	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,910,742	40
41	**Income before Income Taxes (line 30 minus line 40)****	3,271,352	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 3,271,352	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,390	2,692	$ 70,004	$ 26.00	1
2	Assistant Director of Nursing	2,372	2,503	45,432	18.15	2
3	Registered Nurses	33,151	35,366	569,393	16.10	3
4	Licensed Practical Nurses	3,483	3,886	60,886	15.67	4
5	Nurse Aides & Orderlies	72,923	77,592	580,689	7.48	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,870	3,987	37,321	9.36	8
9	Activity Director					9
10	Activity Assistants	7,451	7,804	46,802	6.00	10
11	Social Service Workers	5,040	5,239	43,788	8.36	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,192	23,388	245,635	10.50	15
16	Dishwashers					16
17	Maintenance Workers	2,191	2,335	30,255	12.96	17
18	Housekeepers	21,180	22,400	164,947	7.36	18
19	Laundry					19
20	Administrator	2,496	2,496	120,000	48.08	20
21	Assistant Administrator	822	822	45,425	55.26	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,431	11,776	211,823	17.99	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	188,992	202,286	$ 2,272,400 *	$ 11.23	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 13,872	L1, Col 3	35
36	Medical Director				36
37	Medical Records Consultant	Monthly	1,168	L10, Col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	308	14,615	L10A, Col 3	40
41	Occupational Therapy Consultant	45	2,185	L 10A, Col 3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	88	3,910	L 12, Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	441	$ 35,750		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Henry Mermelstein	Administrator	0.00%	$ 120,000
Marvin Mermelstein	Asst. Admin.	50.00%	45,425
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 165,425

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Altschuler, Melvoin & Glasser LLP	Accounting	$ 8,400
American Experss TBS	Accounting	9,975
Kessler, Orlean, Silver & Co.	Accounting	1,050
Gary A. Weintraub, P.C.	Legal	2,865
Gary A. Weintraub, P.C.	Legal	193
Personnel Planners, Inc.	U/C Consultant	1,110
Patti Black	Court Report	236
Brenda Cohen	Collections	2,035
Immigration & Naturalization	Registration Service	1,415
System Management	Billing Consulting	4,726
Accr-Med Services, Inc.	Computers	4,174
N.H.P.S. Personnel	Employee Recruitment	1,529
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 37,708

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 26,512
Unemployment Compensation Insurance	14,455
FICA Taxes	148,056
Employee Health Insurance	100,807
Employee Meals	20,597
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	4,416
Other Emloyee Benefits	5,081
Allocation from Management	15,847
Profit Sharing Plan	10,000
TOTAL (agree to Schedule V, line 22, col.8)	$ 345,771

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	11,632
Health Care Worker Background Check	
(Indicate # of checks performed)	
Illinois Council on Long Term Care	8,906
Liance Private Newspaper	296
Licenses and Permits - See Attached Sch A	2,702
Learner Newspaper	57
Allocate from Management Co.	13
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,606

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,455
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,455

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 11/01/1999 Ending: 10/31/2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Deferred Maintenance	Various	$ 5,942	3 Years	$	$ 990	$ 1,981	$ 1,981	$ 990	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
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16													
17													
18													
19													
20	TOTALS		$ 5,942		$	$ 990	$ 1,981	$ 1,981	$ 990	$	$	$	$

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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Council on Long Term Care $8,906**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **5,641** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
of Public Aid during this cost report period. $ **134,506**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services fo
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit
on Schedule V. $ **20,597** Has any meal income been offset against
related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Adequate Records are Maintained**
e. Are all vehicles stored at the nursing home during the night and all othe
times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjustec
out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **N/A** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.